Phoebe

COVID-19 VACCINE INFORMATION AND CONSENT FORM

Name (Print): ____

Address: ______________________ ______________ _______ _______
Street City State Zip

Telephone: (______) ____________--____________ **Work Ext or Cell** ______________________

Email: ____

Date of Birth: _______--_______--_________	Age:	**Gender:** ☐Male ☐ Female ☐Other	**Primary Language:** ☐ English ☐Other ____________	**Ethnicity: (check only 1)** ☐ Not Hispanic ☐ Hispanic ☐ Unknown

Race: (check only 1) ☐Asian/Polynesian ☐Black ☐Multiracial ☐White ☐Native Am/Alaskan ☐Unknown

Consent: I have been given a copy and have read, or have had explained to me, the information in the Vaccine Information Statements for the vaccines indicated. I have had the chance to ask questions that were answered to my satisfaction. I believe that I understand the benefits and risks of the vaccines requested and ask that the vaccines indicated be given to me or the person named for whom I am authorized to make this request.

It is suggested that anyone getting a vaccine stay for 15 minutes after getting vaccinated before leaving. Those with previous anaphylactic reactions should stay for 30 minutes.

_______________ ______________________________ X______________________________
Date **Print Name** **Patient/Guardian Signature**

Assignment of Insurance Benefits: I hereby authorize payment directly to the below named clinic and/or physician of any medical insurance benefits otherwise payable to me or on my (the Patient's) behalf and assign all rights to collect such benefits to Phoebe Physician Group.

_______________ ______________________________ X______________________________
Date **Print Name** **Patient/Guardian Signature**

Please answer the health questions below:	**Yes**	**No**	**Don't Know**
Are you feeling sick today? *This includes having any NEW symptom (s) listed below that is not due to another health problem: Fever or chills, cough, shortness of breath, difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, congestion or runny nose, nausea or vomiting, diarrhea.*			
Have you ever received a dose of COVID-19 vaccine?			
If yes, which vaccine product did you receive? Pfizer Moderna Johnson & Johnson			
Have you ever had an allergic reaction to: *(This includes a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital? It also includes an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)*			
• A component of the COVID-19 vaccine, including polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures			
• Polysorbate			
• A previous dose of COVID-19 vaccine			
• A vaccine or injectable therapy that contains multiple components, one of which is a COVID-19 vaccine component, but it is not known which component elicited the immediate reaction.			

Patient Name:			
Patient DOB:			
Please answer the health questions below:	**YES**	**NO**	**Don't Know**
Have you ever had an allergic reaction to another vaccine (other than COVID-19 vaccine) or an injectable medication? (*This includes a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It also includes an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)*			
Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something other than a component of COVID-19 vaccine, polysorbate, or any vaccine or injectable medication? This includes food, pet, environmental, or oral medication allergies			
Have you received any vaccine in the last 14 days? (e.g., flu shot, Shingles, Pneumo, etc.)?			
Have you ever had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19?			
• If yes, was it in the last 14 days?			
Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?			
• If yes, was it in the last 90 days?			
Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?			
Do you have a bleeding disorder or are you taking a blood thinner?			
Are you pregnant or breastfeeding?			
Do you have dermal fillers?			

Vaccine info provided

SIG:

Quantity:

Performed on Date:

NDC:

One of the options below MUST be circled

LOT:

Manufacturer:

One of the options below MUST be circled

Expiration:

Route: IntraMuscular

Injection Site: Right Deltoid ○ Left Deltoid ○

Administered Location: PPMH

Administered by Signature: ______________________________

Administered by Print Name: ______________________________

Additional Comments: